Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EDGE HEALTHCARE GROUP
PO BOX 650268
DALLAS TX 75265

Respondent Name

TEXAS MUNICIPAL LEAGUE INTERGO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3179-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Municipal league denied our claim for timely filing. We sent a request for reconsideration with proof of timely filing that shows we sent the first paper claim on 5/28/2010 8 days after the date of service, but they denied it. Please have them pay our bill. Thank you!"

Amount in Dispute: $624.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No Response submitted

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2010	Professional Services	$624.94	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for health care providers required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-commission Communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim

by a health care provider.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - The time limit for filing has expired
   - Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
   - 16- REPORT NOT RECEIVED

Issues

1. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely and in accordance with Texas Labor Code, §408.027 and Texas Administrative Code §133.10 and §102.4.
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272 (b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the documentation submitted finds that the requestor did not meet the exceptions indicated in Texas Labor Code §408.0272 (b), (c) or (d). Therefore, the requestor was, in this case, required to submit the medical bill no later than 95 days after the service in dispute was provided.
2. Texas Administrative Code §102.4(h) states that "unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the documentation submitted, such as the medical bills, explanation of benefits and the requestor's illegible proprietary system print-out, finds no convincing proof that the provider submitted the medical bill for the services in dispute in compliance with 28 Texas Administrative Code §133.20(b).
3. The division concludes that the medical bills for the services in dispute were not submitted timely. For that reason, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 31, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.